

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>614010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>1/17/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN CARE NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2053 S SHERIDAN DRIVE MUSKEGON, MI 49442</b>	
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F0000 SS=	INITIAL COMMENTS  Christian Care Nursing Center was surveyed for an Abbreviated survey on 1/17/2024.  Intakes: MI00141367.  Census= 43.	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or	F0550	F550 Resident Rights 1. Resident 1 is no longer at the facility. Resident 4 voiced no further concerns and was satisfied with the outcome of the investigation. 2. All residents on the Love Unit were assessed by staff to ensure they are treated with dignity and respect. Interviews will be completed with any any occurrences or concerns will be investigated according to the facility Grievance Procedure or Abuse and Neglect Policy and Procedure. 3. The facility has reviewed the Resident Rights Policy and Procedure and deemed it appropriate. All direct care staff will be educated on Resident Rights. Staff will complete a posttest to ensure knowledge with the policy. 4. The facility will randomly audit 3 residents weekly for 8 weeks to ensure the facility is properly facilitating resident rights. Results of these audits will be submitted to the Quality Assurance and Process Improvement Committee for approval.  The Nursing Home Administrator is responsible for sustained compliance with F550.	2/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/02/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to treat 2 of 4 residents with dignity (R1 and R4), resulting in R1 soiling herself and R4 spilling his urinals on himself because of a staff member's refusal to provide assistance when requested.</p> <p>Findings include:</p> <p>A review of R1's Admission Record, dated 1/17/24, revealed R1 was an 89-year-old resident admitted to the facility on 10/20/23. In addition, R1's Admission Record revealed multiple diagnoses that included cerebral infarction (stroke), generalized muscle weakness, dizziness, anxiety, depression, lack of coordination, incontinence, and a history of falls.</p> <p>A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/3/23, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of "13" which revealed R1 was cognitively intact. In addition, R1's MDS revealed R1 had one-sided impairment of the upper and lower body (arms and legs), was dependent on staff for toileting needs, and needed substantial/maximal assistance (helper does more than half of the effort) with transferring out of bed and into a wheelchair, and needed substantial/maximal assistance transferring on and off of the commode.</p> <p>A review of R4's Admission Record, dated 1/17/24, revealed R4 was a 75-year-old resident</p>			

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	<p>admitted to the facility on 2/22/23 with multiple diagnoses that included left side hemiplegia (paralysis), muscle spasm, depression, anxiety, and urine retention.</p> <p>A review of R4's MDS, dated 11/21/23, revealed a BIMS score of "14" which revealed R4 was cognitively intact. In addition, R4's MDS revealed R4 had one-sided impairment of the upper and lower body (arms and legs) and was dependent on staff for toileting needs.</p> <p>A review of R1's progress note (No Type Specified), dated 11/27/23, revealed that the Executive Director (Nursing Home Administrator) received a concern related to care and the concern was reported to the State Survey Agency (SSA) through the State's Facility Reported Incident (FRI) reporting system.</p> <p>A review of the facility's investigation documentation for incident on 11/26/23 revealed on 11/26/23 between 2:30 AM and 5:30 AM, R1 stated that Certified Nursing Assistant (CNA) "A" failed to assist her to the restroom when she requested to use it. She stated CNA "A" also "roughly" pushed her feet onto her bed after assisting her into bed. The facility's investigation documentation also revealed that the Nursing Home Administrator (NHA) was not notified of the incident until 1:45 PM on 11/27/23.</p> <p>A review of Minimum Data Set Coordinator (MDS) "F"'s interview, dated 11/27/23, revealed MDS "F" reported that during a meeting with R1 and R1's daughter, R1 mentioned that she woke up at 2:30 AM and wanted to go to the bathroom. She stated "one girl" (later identified as CNA "A") told her that she did not have to go to the bathroom and she would change her brief. R1 told CNA "A" that she wanted to get up to use the bathroom, but CNA "A" told her she did not need</p>			

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	<p>to. R1 stated she woke back up at 5:00 AM and she was very wet. She stated she asked CNA "A" to get her up again to use the bathroom and get changed and CNA "A" refused to get her up. R1 stated she continued to insist on getting up, so CNA "A" "threw my feet over the edge of the bed and put my shoes on, grabbed me under my arm to pick me up. I told her it hurt and she stated I am not hurting you." MDS "F" also stated that R1 told her that on 11/25/23, while she was getting ready for bed, CNA "A" was "messaging around with her phone." R1 told MDS "F" that after she had washed her face and brushed her teeth the same aide (CNA "A") grabbed her to pick her up and R1 fell over onto the bed. CNA "A" then told R1 that she can get up herself. When R1 could not get up herself, CNA "A" grabbed her and put her in the chair very roughly. R1 kept telling CNA "A" that she was hurting her when she was helping her into bed and into the chair. However, CNA "A" told her she was not hurting her during the transfers.</p> <p>A review of CNA "A"'s interview, dated 11/28/23 at 10:00 AM, revealed that she assisted R1 to the bathroom early in the morning (on 11/26/23) after R1's brief was wet. She stated that she did help R1 back to bed after she changed her brief. CNA "A" stated that she did assist R1 with her shoulders when she was getting her back to bed, but CNA "A" stated she placed her arm on the outside of R1's shoulder, not under her arm. She stated she was aware that R1 was complaining that her shoulders were hurting, "but that had been a long-standing issue because she communicated to the nurse that [name of R1] needed a painkiller because of pain." CNA "A" stated she does pick up R1's legs and places them on the bed upon transfers. CNA "A" denied she ever threw R1's legs into bed or that R1 ever told her that she (CNA "A") was hurting her. CNA "A" also stated she did not see R1 fall onto her bed. CNA "A" stated she did not know the time</p>			

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	<p>that she assisted R1 to the bathroom with her wet brief.</p> <p>A review of R4's undated interview revealed R4 stated CNA "A" "does not answer call lights. I had mine on she never comes in." R4 further stated he uses his call light when he needs staff to empty his urinals. He stated he did not think that CNA "A" understood that when he puts his call light on, he needs his urinals emptied because they are full. R4 also stated that he would "spill p*ss all over myself" (due to having to use his urinals when they were mostly full). R4 stated CNA "A" "was useless."</p> <p>A review of CNA "C"'s interview, dated 12/4/23, revealed CNA "C" recalled assisting CNA "A" once during the shift to provide care to R1 in the early hours of 11/26/23 (time not indicated). She stated that they (CNA "A" and CNA "C") responded to R1's call light and R1 was soiled with urine. CNA ""C stated that R1 refused to allow them to change her at that time (at 2:30 AM, 5:00 AM, or some other time during the shift). CNA "C" also stated that she was present when R1 was assisted into bed after getting ready for bed on 11/25/23. She denied that R1's legs were put into bed roughly.</p> <p>A review of Registered Nurse (RN) "D"'s undated interview revealed, "[Name of CNA "A"] is just worthless. She doesn't do anything but sit around on her phone. Residents are in bed with the same shirt they wore all day. She does not do thorough cares."</p> <p>A review of RN "E's undated interview revealed, "CNA "A" "just doesn't respect authority. She doesn't have the patience to be able to do her job. She is always on her phone and disappearing."</p> <p>During an interview on 1/17/24 at 2:55 PM, R4</p>			

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	stated since the incident with R1 occurred two months ago he did not specifically remember if CNA "A" would not empty his urinal or answer his call light . He stated he did remember that the residents did have issues with the nursing assistants not answering call lights "about a month or two ago", but did not remember specific staff members or the shift(s) that the issues occurred on.				